JCS FAMILY
20 YEARS OF EMPOWERING LEARNERS

JCS-Inc. Family of Charter School

Physician/Medication Authorization Form

STUDENT'S LAST NAME	FIRST	MIDDLE	AGE	BIRTH DATE (MM/DD/YY)

ACADEMY OR LEARNING CENTER	PRINCIPAL OR ACADEMY COORDINATOR	ADVISOR OR TEACHER

The California Education Code relating to the giving of medications at school states:

> **49423**. Notwithstanding Section 49422, any pupil who is required to take, during the regular school day, medication prescribed for him or her by a physician or surgeon, may be assisted by the school nurse or other designated school personnel or may carry and self-administer prescription auto-injectable epinephrine if the school district receives 1) written statement from such physician detailing the method, amount and time schedules by which such medication is to be taken and 2) a written statement from the parent or guardian of the pupil indicating the desire that the school district assist the pupil in the matter set forth in the physician's statement.

All JCS-Inc. Charter Schools have implemented the following procedure. The information requested on this form is necessary to comply with the law and to insure adequate protection for students.

TO BE COMPLETED BY A LICENSED PHYSICIAN

A. **Nature of the condition** requiring medication during the regular school day

_____

B.

NAME OF MEDICATION	METHOD OF ADMINISTRATION	DOSAGE	APPROXIMATE TIME OF DAY
1.			
2.			

C. **DISCONTINUE USE OF MEDICATION 1 ON :** _____ Date **DISCONTINUE USE OF MEDICATION 2 ON :** _____ Date

D. **Upon receipt of medication orders, the school personnel and physician shall consult as needed. Please note that a school nurse is not on staff at the school site. School personnel will not administer *non-emergency* injections.**

E. Do you wish to talk briefly, by telephone, with school personnel at intervals to discuss the effect of medication? If so, indicate approximate interval:

_____

PRINT PHYSICIAN'S NAME	LICENSE NUMBER	PHONE

PHYSICIAN'S SIGNATURE	DATE

I agree with the above:

PARENT/GUARDIAN'S SIGNATURE	DATE

Back of this form must be completed by parent or guardian

TO BE COMPLETED BY PARENT OR GUARDIAN

1. Please have an **adult** deliver the medication and completed form to the school.

2. Medication must be in its original container, labeled with the student's name, name of medication, dosage and include any necessary equipment for administration (e.g. spoon for liquid medication)

3. After the date for discontinuance of medication specified by the physician, changes to or continuance of the arrangements must be secured by filling out a newly dated copy of this form. All medication requests must be renewed each school year if continuation of the medication is necessary.

4. I understand that there is no school nurse on staff and I request that the coordinator or other designated personnel, administer the medication as directed by the physician on the front of this sheet. I understand that designated school personnel have my permission to communicate with the prescribing physician on matters related to this medication. I agree to save and hold the school, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

_____ _____

PARENT OR GUARDIAN'S SIGNATURE **DATE**